ATTACHMENT J-8

TRICARE MANAGEMENT ACTIVITY (TMA)

APPLICATION FOR TRICARE MENTAL HEALTH FACILITY CERTIFICATION

Facility_____

Please check one appropriate facility/program:

- ☐ Psychiatric partial hospitalization program (PHP)
- ☐ Residential treatment center (RTC)
- ☐ Substance use disorder rehabilitation facility (SUDRF)
  (See question 3.4 before beginning the application process)

All applications must be signed and dated by the Chief Executive Officer.

The above-named facility has made an application either to become a TRICARE-certified facility or to continue to provide care under TRICARE certification. The signee certifies that the information contained in this application is true and accurately represents the above-named facility.

_____ _____

Chief Executive Officer Date

APPLICATION FOR TRICARE MENTAL HEALTH FACILITY CERTIFICATION

Instructions: To allow us to process this application, you must complete all sections of the application.

1.0 Identifying Information:

1.1 Provide the full name, address, telephone number, facsimile number, IRS tax ID number, e-mail address, and website address for your facility.

Name of Facility
dba

Physical Address of program requesting certification*	City	State	Zip
Mailing Address (if different)	City	State	Zip
Telephone Number		Facsimile Number	
IRS Tax Number (EIN)*	E-Mail Address	Website	

* Facilities with programs located at multiple locations must submit a separate complete application for each location.

1.2 Send All Correspondence To:

Point of Contact Name		Title
Street Address		PO Box Number
City	State	Zip
Telephone Number	Facsimile Number	E-Mail Address

1.3 Corporate Ownership: If your facility is owned by a corporation, provide the full name, mailing address, telephone number, and IRS tax ID number of the corporate owner or affiliate.

_____

Name of Corporation

_____

Street Address PO Box Number

City State Zip Code

Telephone Number IRS Tax ID (EIN)

2.0 Composition of Administration: Provide the names, graduate and post-graduate degrees for the administrative personnel of this facility.

Chief Executive Officer (CEO) Degree(s)

Medical Director(s) Degree(s)

Clinical Director(s) (If Applicable)* Degree(s)

*TRICARE standards for PHPs and RTCs require that the clinical director be a psychiatrist or doctoral level psychologist. The medical director may also serve as the clinical director if he/she fulfills the responsibilities of the clinical director as stated in TRICARE standard I.F for RTCs and TRICARE standard I.E for PHPs. TRICARE Standards for SUDRFs require that the clinical director meet one of the following requirements: is a physician with certification by ASAM, is a physician with one year or 1,000 hours of experience in the treatment of psychoactive substance use disorders, or is a psychiatrist or doctoral level psychologist. The medical director may also serve as the clinical director if he/she fulfills the responsibilities of the clinical director as stated in TRICARE standard I.F for SUDRFs.

3.0 FACILITY DESCRIPTION

3.1 Does the program (s) requesting certification share physical space or program schedules with other programs such as acute care, RTC, inpatient rehabilitation, or substance use partial hospitalization?

☐ Yes ☐ No If yes, please describe.

3.2 Program/Unit Information: Complete the table below for each program(s)/units(s) for which certification is requested.

Program/Unit Name	Days of Operation	Hours of Operation	Capacity*			Age Range	
			M	F	Total	From	To

***** Capacity is defined as the maximum number and mix of patients for whom the program is designed to provide services.

3.3 Specific Requirements for PHPs: PHPs are required to complete section 3.3. RTCs and SUDRFs do not need to complete this section.

PROGRAM REQUIREMENTS	RESPONSE	DOCUMENTATION LOCATION
Does the facility provide academic educational services?	☐ Yes* ☐ No	

*****If yes, please indicate the number of hours per day of academic education.

Program name _____ Hours/day_____

Program name_____ Hours/day_____

Program name_____ Hours/day_____

3.4 Specific Program Requirements for SUDRFs: SUDRFs are required to complete section 3.4. PHPs and RTCs do not need to complete this section.

PROGRAM REQUIREMENTS	RESPONSE	DOCUMENTATION LOCATION
Is the facility certified as a hospital by TRICARE or Medicare?	☐ Yes** ☐ No	_____

******If yes, do not complete this application. Your local TRICARE Managed Care Contractor (MCC) is responsible for certification of Medicare or TRICARE participating hospitals. Please call your MCC regarding the application process.

All facilities must respond to the following sections:

3.5 Operational Information: Has the facility been fully licensed and in operation for a minimum of six months?

☐ Yes ☐ No

Initial applicants only: Has the census of the program(s) requesting certification been at least 30% of the capacity for the past six months?

☐ Yes ☐ No

Recertification applicants only: Has the currently certified program(s) treated at least one TRICARE beneficiary in the previous 24 months?

☐ Yes ☐ No

3.6 Specialty programs offered: List any specialty tracks that are included within the program(s) requesting certification (example: dual diagnosis track).

_____

_____

4.0 Program Requirements: Check the appropriate response. TRICARE regulation requires that your facility meet all of the program requirements listed below. **A "yes" response indicates that your facility has reviewed the TRICARE standards for the facility type for which you are applying, and attests that your program(s) meets these standards.** The TRICARE Standards were included for your reference in the application packet. Each requirement below lists the specific standard to which you should refer.

4.1 Program Requirements for All Facilities:

PROGRAM REQUIREMENTS	RESPONSE
a. Does the facility/program have a valid state or federal license to operate? *Refer to TRICARE Standard I.B.*	☐ Yes ☐ No
b. Does the program(s) comply with all TRICARE charting requirements, including weekly notes by the physician or doctoral level psychologist? Note: Inpatient detoxification programs must have daily physician notes. *Refer to TRICARE Standard II.K for all charting requirements*	☐ Yes ☐ No
c. Does the facility have a written agreement with an ambulance company to provide emergency transportation? *Refer to TRICARE Standard II.M.1*	☐ Yes ☐ No
d. Does the facility have a written agreement with an authorized hospital for emergency medical/surgical and mental health care? *Refer to TRICARE Standard II.M.1*	☐ Yes ☐ No
e. Does the facility make available during service hours, either directly or through contractual arrangement, the physical health services necessary for patient evaluation and treatment? *Refer to TRICARE Standard II.M.2*	☐ Yes ☐ No

f. When appropriate, does the facility provide, or contract for all pharmacy services? ☐ Yes ☐ No
Note: Psychiatric Partial Hospitalization Programs (PHPs) and Substance Use Partial Hospitalization Programs (SUPHs) are not required to provide pharmacy services; PHPs and SUPHs may answer no to this question if patients are responsible for their own medications.
Refer to TRICARE Standard II.M.3

5.0 Documentation Requirements: Please submit the following documents with this application. We have included a "Documentation Checklist" to assist in compiling a complete application. Documents may be provided on diskette as computer generated files, or as scanned documents, or you may provide hard copies.

Document A: Provide a copy of the most recent JCAHO accreditation letter using the *Comprehensive Accreditation Manual for Behavioral Health Care.* Include the survey findings and recommendations including Type I and Type II recommendations. For SUDRFs, provide a copy of the most recent JCAHO accreditation letter using the *Comprehensive Accreditation Manual for Behavioral Health Care* or the CARF accreditation letter, survey findings, and recommendations to include Type I and Type II recommendations.
Refer to TRICARE Standard I.B

Note: TRICARE standards require that facilities have JCAHO accreditation under the *Comprehensive Accreditation Manual for Behavioral Health Care.* Accreditation under the *Comprehensive Accreditation Manual for Hospitals* is not sufficient.

Document B: Provide a copy of the mission statement, philosophy, goals, objectives, and organizational chart. *Refer to TRICARE Standard I.C and I.D*

Document C: Provide a copy of the program's Plan for Professional Services.
Refer to TRICARE Standards I.D and II.B

Document D: Provide resumes or curriculum vitae for the Administrator/Chief Executive Officer, Medical Director(s), and Clinical Director(s), if applicable.
Refer to TRICARE Standards I.D, I.E, and I.F

Document E: Staffing Tables

Complete the attached staffing table for each program requesting certification. The staffing table MUST include each staff member's name, educational degree, position, hours worked per week, program/unit to which staff member

is assigned, hours worked on each program, type of license/certification, and license/certification number. *Refer to TRICARE Standards II.A and II.B*

Please remember to include all clinical staff, including physicians, nurses, therapists, activity therapists, mental health workers, and teachers. Therapists must be master's prepared and licensed or certified by the state in which the facility is located. If they are unlicensed, your facility must confirm that the unlicensed therapists are actively working towards licensure and receive weekly, documented supervision with their clinical entries countersigned. Activity therapists must be bachelor's prepared and licensed or certified nationally or by the state in which the facility is located. Teachers must be bachelor's prepared and certified by the state in which the facility is located.

RTCs must also include a copy of the RTC nursing schedule for the month prior to the month in which this application is submitted to document that registered nursing coverage is maintained 24 hours per day for the RTC.

Document F: Provide a copy of written policies and procedures for behavioral management. Include policies related to seclusion, restraint, time-out, and other special treatment procedures. Include a description of any level systems used in the program(s). *Refer to TRICARE Standard II.D*

Note: TRICARE standards require that physician orders for seclusion or restraint, including physical restraint be obtained within 30 minutes of implementation for RTCs and within one hour for PHPs and SUDRFs.

Document G: Provide a copy of the admission criteria. Also, provide copies of all parent information provided. *Refer to TRICARE Standard II.E*

Document H: Provide a copy of written policies for patient assessments. Include time frames for completion of all patient assessments, **including a clinical formulation** and the staff member responsible for completing each assessment. Include a copy of all assessments. *Refer to TRICARE Standards II.F and II.G*

Document I: Provide a copy of written policies for treatment planning. Include a blank treatment plan form and time frames for completion. *Refer to TRICARE Standard II.H*

Document J: Provide a program schedule and program narrative for each program requesting certification.

The program schedule must include the names of staff designated to lead each group that is listed on the schedule. *Refer to TRICARE Standard II.L*

Note: Psychotherapy groups must be provided and must be led by master's prepared professionals. Activity therapy groups must also be provided. PHPs and RTCs must provide a range of activity therapy groups each week that are led by a bachelor's prepared certified activity, occupational, or expressive therapist. SUDRFs must provide a range of activity therapy groups that are supervised and directed by a bachelor's prepared certified activity, occupational, or expressive therapist. RTCs must provide clinical services SEVEN days per week, which must include an activity therapy group or a psychotherapy group.

Document K: Provide a description of the academic educational program(s) for children and adolescents, including type, location, and provider of this program. *Refer to TRICARE Standard II.L*

Document L: Provide a copy of the floor plan of the program(s) requesting certification. If the facility is in multiple buildings, clearly designate the buildings by address and location. **Label the programs and the room space on the floor plan.** *Refer to TRICARE Standards III.A and III.B*

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STAFFING TABLE

Name	Degree	Position	Hours/ Week	Program/ Unit Name	Hours/ Program	Type of License/ Certification	License/ Certification No.

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DOCUMENTATION CHECKLIST

We have included this checklist to assist you in compiling a complete application.

No.	Description	
A	JCAHO or CARF for SUDRFs, accreditation letter, survey findings, recommendations, and plan of correction	☐
B	Mission statement, philosophy, goals, objectives, and organizational chart	☐
C	Plan for professional services	☐
D	Resumes: administrator (CEO), medical director, clinical director	☐
E	Staffing table	☐
F	Behavioral management policies, including seclusion, restraint, and other special treatment procedures (STPs)	☐
G	Admission criteria	☐
H	Patient assessments policies	☐
I	Treatment planning policies	☐
J	Program narrative(s) and program schedule(s) with the names of staff designated to lead each group	☐
K	Description of academic educational programs	☐
L	Floor plan	☐